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DATE: **12/5/2018**

TO: **All Sysco Injury Protection Participants**

FROM: **Risk Management**

SUBJECT: **Summary of Material Modifications to the Sysco Injury Protection Plan (SIPP)**

NOTICE TO ENGLISH SPEAKING ASSOCIATES: If you have difficulty understanding any part of this memo, contact the Risk Management Department at 1390 Enclave Parkway, Houston, Texas 77077, (281) 584-1390.

AVISO A LOS ASOCIADOS QUE NO HABLAN INGLES: Si tiene dificultad en entender cualquiera parte de este memorándum, comuníquese con el Departamento de Manejo de Riesgo: Risk Management Department, 1390 Enclave Parkway, Houston, Texas 77077, (281) 584-1390.

The following changes have been made to your Summary Plan Description ("SPD") for the Sysco Injury Protection Plan. Please keep this memo with the SPD booklet you previously received. Any inconsistencies between this memo and the SPD booklet will be governed by the terms of this memo.

THE FOLLOWING CHANGES ARE EFFECTIVE JANUARY 1, 2019:

1. **WAGE REPLACEMENT BENEFITS:** The "When Wage Replacement Benefits Begin" section has been amended to increase the amount of Pre-Injury Pay you will receive after the first four weeks of Total or Partial Disability (as determined by an Approved Physician) and now reads as follows:

   When Wage Replacement Benefits Begin

   - **Total Disability.** From the first full day that you become Totally Disabled due to a covered Injury, the Plan shall pay Wage Replacement Benefits equal to 100% of your Pre-Injury Pay for the first four weeks of Total Disability, and 90% of your Pre-Injury Pay thereafter.

   - **Partial Disability.** From the first full day that you become Partially Disabled, the Plan shall pay Wage Replacement Benefits equal to 100% of the portion of your Pre-Injury Pay that you are unable to earn for the first four weeks of Partial Disability, and 90% of the portion of your Pre-Injury Pay that you are unable to earn thereafter (due to the Approved Physician's restrictions) while working Modified Duty.

- If you have a Partial Disability and are released to Modified Duty but (i) the Employer has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

- If you have a Partial Disability and have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Modified Duty position, but you are either:

  - again determined by an Approved Physician to be Totally Disabled, or
  - the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment;

  then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

The Employer's ability to provide Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Modified Duty position for the purposes of the American with Disabilities Act ("ADA").

- **Payment Terms and Other Limitations.** An Approved Physician must make the determination regarding whether you are Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator. Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Replacement Benefit payments shall be reduced as described in the "Offset For Other Benefits" section of this booklet.

2. **REQUESTING BENEFITS:** The "Notice of Injury" section has been amended to extend the deadline to provide verbal notice of an Injury and together with the "Providing Required Information" section now reads as follows:

<u>Notice of Injury</u>

You (or your Representative) must provide verbal notice of an Injury, no matter how minor, to your Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services.

- **For an Injury due to an Accident, or known exposure to an Occupational Disease, this verbal notice must be provided by the end of the next calendar day following the date of the Accident or Injury.**

- **For an injury due to an occupational disease (not known at the time of the alleged exposure) or cumulative trauma, you must report your injury by the earliest of:**

  a) **The end of the next calendar day following the date you are medically diagnosed with an occupational disease or cumulative trauma, or**

  b) **30 days from the date you should have known of your occupational disease or cumulative trauma.**

You must also notify your Supervisor (verbally or in writing) of your expected recovery time (1) immediately after receiving your first medical treatment for an Injury, and (2) after each following appointment with your treating Approved Physician.

Providing Required Information

You (or your Representative) must complete the incident report form and medical authorization form **within 24 hours after the Injury is reported**. These forms must be submitted to your Supervisor (or such other person as the Claims Administrator may specify). You must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may direct from time-to-time.

An immediate incident report to your supervisor is essential so that the Claims Administrator can promptly verify the facts regarding your Injury and pay appropriate benefits. No benefits will be payable under the Plan if:

- notice of Injury is not provided as specified above, unless the Claims Administrator determines that Good Cause exists for failure to give notice in a timely manner; or

- all required information is not provided as specified above, unless the Claims Administrator determines that Good Cause exists for failure to provide such information in a timely manner.

3. **MEDICAL BENEFITS:** The "First and Continuing Treatment" requirements have been amended to (1) extend the deadline by which you must receive initial medical services or supplies from within 14 days following the date of your Injury to within 14 days following the date your Injury *is reported*, and (3) add a Good Cause exception to the Plan's exclusion of further Medical Benefits if you do not receive medical treatment from an Approved Physician or Approved Facility for a period of more than 60 days. The amended "First and Continuing Treatment" section now reads as follows:

First and Continuing Treatment

- The first Covered Charge must be received from an Approved Physician and incurred within 14 days following the date Injury the Injury is reported (unless the Claims Administrator determines that Good Cause exists);

- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician or Approved Facility for a period of more than 60 days (unless the Claims Administrator determines that Good Cause exists).

    - This subsection shall not apply if the Claims Administrator has approved scheduled medical treatment with an Approved Physician or Approved Facility during the applicable 60-day period, even if such medical treatment occurs beyond the 60-day period.

    - This subsection shall also not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

4. **DEFINITIONS:** A definition for Good Cause has been added to read as follows:

   "Good Cause" means circumstances existed that you could not foresee and were beyond your control. As part of its investigation, the Claims Administrator may require you and Employer to produce evidence in order to establish the existence of good cause. The Claims Administrator shall consider relevant evidence from its investigation in order to determine whether good cause exists in a particular circumstance.

5. **APPENDIX C:** Appendix C entitled "RECEIPT, SAFETY PLEDGE AND DISPUTE RESOLUTION ACKNOWLEDGMENT" has been amended to (a) reflect the change in the deadline for you to provide "Notice of Injury" as indicated in No. 1 above and (b) to reflect the change in the deadline by which you must receive initial treatment with an Approved Physician or Approved Facility as indicated in No. 3 above.

THE FOLLOWING CHANGES WERE EFFECTIVE ON APRIL 2, 2018:

1. **DEFINITIONS:** The definition of an "Adverse Benefit Determination" has been amended to read as follows:

   "Adverse Benefit Determination" means a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit. An "Adverse Benefit Determination" may also be a denial, reduction, termination, or failure to provide or make payment that is based on a determination of your or your Beneficiary's eligibility to participate in the Plan.

   - With respect to a claim for Medical Benefits, the term "Adverse Benefit Determination" includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service (for which benefits are otherwise provided) because the item or service is determined to be experimental, investigational or not Medically Necessary or appropriate.

   - With respect to a claim for Wage Replacement Benefits, the term "Adverse Benefit Determination" also means any rescission of your Wage Replacement Benefit coverage (whether or not, in connection with the rescission, there is an adverse effect on a particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect.

2. **CLAIM PROCEDURES:** The "Detailed Claim Procedures" included in your SPD have been amended to read in their entirety as follows:

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

An initial claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan will be initiated by you (or your Representative) complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS and MEDICAL MANAGEMENT sections of this booklet. A claim for Medical Benefits can also be directly submitted to the Claims Administrator by a health care provider (for example, submitting a written pre-authorization request for your medical treatment or submitting invoices for medical treatment you have already received). A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing written or electronic notice of entitlement thereto to the Claims Administrator within 90 days after the date of your death.

- **What is a Claim:** Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Dismemberment Benefits or Death Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- **Who is a Claimant:** A claimant may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIM PROCEDURES section to "claimant" may include you, a health care provider seeking payment for a service or supply, or a claimant's authorized Representative, as applicable. The Plan shall have the right to establish reasonable procedures for determining whether and to what extent an individual has been authorized to act on your behalf. However, with respect to an Urgent Care Claim, a physician or other health care professional (1) licensed, accredited or certified to perform specified health services consistent with state law, and (2) with knowledge of a claimant's medical condition shall be permitted to act as the authorized Representative of the claimant.

- **Information to Submit:** Claims must include the information required by the REQUESTING BENEFITS section above and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Plan have not been reimbursed, or are not reimbursable under any other plan or program. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet. The Claims Administrator may rely upon all such

information furnished by the claimant, including the claimant's current mailing address, and shall have no obligation or duty to locate a claimant.

- **Submission of Medical Bills for Payment:** Approved Physicians and Approved Facilities will be requested to invoice all healthcare-related charges directly to the Claims Administrator (or the Employer, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Physician, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.

- **Incomplete Claim Submissions:** If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIM PROCEDURES section, **if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.**

- **Impartiality:** The Plan shall ensure that all claims and appeals for benefits are determined in a manner designed to ensure independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjuster or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Timing of Notice of Initial Benefit Determination

An initial benefit determination that approves Plan benefits can be communicated verbally, in writing or by electronic notice. Except as described below with respect to an Urgent Care Claim, an initial benefit determination that is an Adverse Benefit Determination must be provided in writing or by electronic notice. The Claims Administrator will provide notice to the claimant of its initial benefit determination as follows:

- **Urgent Care Medical Benefit Claims:** In the case of an Urgent Care Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim.

    - Notification of an Adverse Benefit Determination for an Urgent Care Claim may be provided to the claimant orally within the timeframes specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification.

- If the claimant (1) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (2) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then the Claims Administrator will have the following additional notice requirement. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

    - The Claims Administrator will notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. Notification may be oral, unless the claimant requests written notice.

    - The claimant will then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.

    - The Claims Administrator will then notify the claimant of the Plan's initial benefit determination as soon as possible, but not later than 48 hours after the earlier of (1) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (2) the end of the time period given the claimant to provide such information.

- **Concurrent Medical Care Decisions:** If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:

    - The Claims Administrator will notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination will be considered an Adverse Benefit Determination and the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit determination on review before the course of treatment is actually reduced or terminated.

    - Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies of the claim, as follows:

        - The Claims Administrator will make an initial benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

        - Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with the "Manner and Content of Adverse Benefit Determinations" section of this booklet.

- **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim.

    - If the claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, then the Claims Administrator will notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedure to follow. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

    - The Claims Administrator may extend the 15-day benefit determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision.

    - If additional information is necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.

- **Post-Service Medical Benefit Claims and Wage Replacement Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim.

    - The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.

    - If the extension relates to a claim for Wage Replacement Benefits, such notice will also state (1) the standards on which entitlement to benefits is based, and (2) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues.

    - If additional information is requested with the extension notice, the claimant will have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.

- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismemberment Benefits or Death Benefits, the Claims Administrator shall notify the claimant of an Adverse Benefit Determination within 90 days after its receipt of the claim.

    - The Claims Administrator may extend this period up to an additional 90 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan.

    - Notice of such extension must be provided to the claimant prior to the expiration of the initial 90-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.

Manner and Content of Adverse Benefit Determinations

If the initial benefit determination is an Adverse Benefit Determination, the Claims Administrator will provide a written or electronic notice to the claimant. Any electronic notice shall comply with ERISA regulations that specify the standards for electronic disclosure of benefit plan information.

- **General Requirements:** The notification to the claimant shall be written in a manner calculated to be understood by the claimant and shall include:

    - The specific reason or reasons for the Adverse Benefit Determination;

    - References to the specific Plan provisions on which the Adverse Benefit Determination is based;

    - A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

    - A description of the Plan's review procedures and the time limits applicable to such procedures; and

    - A statement that following an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant has a right to bring a legal action under ERISA section 502(a).

- **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Medical Benefits, the notice shall include the following additional information:

    - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy thereof shall be provided free of charge to the claimant upon request;

    - If the Adverse Benefit Determination is based upon medical necessity, an experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the

claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request; and

- If the initial Adverse Benefit Determination is in response to an Urgent Care Claim, a description of the expedited review process applicable to such claims.

➢ **Additional Requirements for Wage Replacement Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Wage Replacement Benefits, the notice shall be provided in a culturally and linguistically appropriate manner (as described in this DETAILED CLAIM PROCEDURES section) and shall include the following additional information:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

  - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant;

  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and

  - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

- If the Adverse Benefit Determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Filing an Appeal

Except as otherwise provided below, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 180 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

➢ The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee will take all of such

information into account when reviewing the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to the claimant's claim for benefits (as determined by the Appeals Committee).

- In the case of an Adverse Benefit Determination of an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.

- In the case of an Adverse Benefit Determination of a Dismemberment Benefit Claim or a Death Benefit Claim, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 60 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

Appeal Committee Review

When reviewing the appeal of an Adverse Benefit Determination for Medical Benefits or Wage Replacement Benefits, the Appeals Committee shall comply with the following requirements:

- The Appeals Committee review will not give any deference to the claimant's initial Adverse Benefit Determination.

- If the appeal request is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Committee will consult with an Approved Physician who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Physician will not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual.

- Upon request of a claimant, the Appeals Committee will identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination, without regard to whether the advice of such experts was relied upon in making the benefit determination.

- Before the Plan issues an Adverse Benefit Determination on review, the Appeals Committee shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to the date.

- Before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, the Appeals Committee shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to that date.

Timing of Notice of Benefit Determination on Review

The Appeals Committee will provide notice to the claimant, as described below, of the Plan's benefit determination on review in accordance with the following timeframes:

- **Urgent Care Medical Benefit Claims:** In the case of an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request.

- **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request.

- **Post-Service Medical Benefit Claims and Wage Replacement Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within 45 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 45 days if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.

- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismemberment Benefits or Death Benefits, the Appeals Committee shall notify the claimant of the Plan's benefit determination on review within 60 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 60 days if the Appeals Committee determination that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 60-day period and indicated (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.

Manner and Content of Benefit Determination on Review

The Appeals Committee will provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notice shall comply with ERISA regulations that specify the standard for electronic disclosure of benefit plan information.

- **General Requirements:** If the determination on review is an Adverse Benefit Determination, the notice shall be written in a manner calculated to be understood by the claimant and shall include:

  - The specific reason or reasons for the Adverse Benefit Determination;

  - References to the specific Plan provisions on which the Adverse Benefit Determination is based;

  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

  - A statement of the claimant's right to bring an action under ERISA section 502(a).

- **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Medical Benefits, the notice shall include the following additional information:

  - The additional requirements for Medical Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and

  - The following statement (if applicable): "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find what may be available is to contract your local U.S. Department of Labor Office and your State Insurance regulatory agency."

- **Additional Requirements for Wage Replacement Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Wage Replacement Benefits, the notice shall include the following additional information:

  - The additional requirements for Wage Replacement Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and

  - With respect to the statement of claimant's right to bring an action under ERISA section 502(a), any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

Standards for Culturally and Linguistically Appropriate Notices

The Plan shall comply with the following standards for culturally and linguistically appropriate notices:

- **Claims Assistance:** The Plan shall provide oral language services that include answering questions in any applicable non-English language and shall provide assistance with filing claims and appeals in any applicable non-English language.

- **Claimant Requests:** The Plan shall provide, upon request, a notice in any applicable non-English language.

- **Notice:** The Plan shall include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

Extension of Timeframes Allowed by Law or Agreement

In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended timeframes.

- This discretion will only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (for example, additional time is needed to obtain an appointment and results of a medical examination).

- Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.

Exhaustion of Administrative Remedies

No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Plan decision shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

Este folleto y este formulario contienen información importante sobre sus derechos. Al dorso de este formulario encontrará la información en español. Si tiene dificultad en entender cualquier parte de este folleto, comuníquese con el Departamento de Manejo de Riesgo, Risk Management Department, al (281) 584-1390.

APPENDIX C

RECEIPT, SAFETY PLEDGE AND DISPUTE RESOLUTION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Sysco Injury Protection Plan, updated effective March 1, 2014.

INJURY NOTICE AND MEDICAL TREATMENT. I understand and agree that if I am injured on the job, I must notify my Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services **no later than the end of the next calendar day following the date of the Injury.** I further understand and agree that in order to receive benefits under the Plan, I must treat with Plan-approved physicians and facilities and receive my first treatment from a Plan-Approved physician or facility within 14 days of the date my injury is reported.

SAFETY PLEDGE. I agree to familiarize myself with the safety program for the Employer and to perform my job according to the general and departmental safety rules of the Employer. I will also use any personal protective equipment that is provided to me. I also agree to immediately report to my supervisor any accident that involves another associates, a customer, a vendor, or me. I will also immediately report any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and actively participate in any Employer safety training programs.

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that **claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Employer and me) must be submitted to an arbitrator,** rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with the Employer at any time on or after March 1, 2014, I am accepting and agreeing to comply with these dispute resolution requirements. I understand that the Employer is also accepting and agreeing to comply with these dispute resolution requirements. All covered claims brought by my spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns are also subject to the Employer's dispute resolution policy, and any decision of an arbitrator will be final and binding on such persons and the Employer. **I understand that the arbitrator, and not a judge or jury, has the exclusive authority to resolve any dispute about the enforceability of this dispute resolution process.**

X _____ Associate's Signature	_____ Date
_____ Print Associate's Name	_____ Associate's Identification Number
_____ Parent or Legal Guardian Signature (if Associate under age 18)	_____ Date
_____ Print Parent or Legal Guardian Name	_____ Associate's Work Location or Department

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APÉNDICE C

RECIBO, COMPROMISO DE SEGURIDAD Y ADMISIÓN DE RESOLUCIÓN DE CONFLICTOS

RECIBO DE MATERIALES. Con mi firma a continuación, acepto que recibí y leí (o tuve la oportunidad de leer) la Descripción Resumida del Plan (*Summary Plan Description*, "SPD") del Sysco Injury Protection Plan actualizado, vigente a partir del 1.° de marzo de 2014.

AVISO DE LESIÓN Y PROVEEDORES TRATAMIENTO MÉDICOS. Entiendo y acepto que si estoy lesionado en el trabajo, debo notificar a mi supervisor, Gerente de seguridad, Gerente de recursos humanos, Gerente de gestión de riesgos o servicios de salud a más tardar el final del siguiente día calendario después de la fecha de la lesión. También entiendo y acepto que para recibir beneficios bajo el plan, debo tratar con médicos e instalaciones aprobados por el plan y recibir mi primer tratamiento de un médico o instalación aprobado por el plan dentro de los 14 días de la fecha en que se reporta mi lesión.

COMPROMISO DE SEGURIDAD. Acepto familiarizarme con el programa de seguridad del Empleador y desempeñar mi trabajo según las reglas de seguridad generales y departamentales del Empleador. También usaré todo equipo de protección personal que se me proporcione. Además, acepto informar inmediatamente a mi supervisor sobre cualquier accidente que involucre a otro asociado, a un cliente, a un proveedor o a mí. Asimismo, informaré de inmediato sobre cualquier acción, condición o equipo inseguros. Por último, cooperaré con cualquier investigación de accidentes y participaré activamente en cualquier programa de capacitación de seguridad del Empleador.

ARBITRAJE. También reconozco que esta SPD incluye una política obligatoria de la compañía que requiere que **los reclamos o conflictos relacionados con la causa de una lesión en el trabajo (que no puedan resolverse de otro modo entre el Empleador y yo) deben ser presentados ante un árbitro**, en lugar de un juez y jurado en un tribunal. Entiendo que al recibir esta SPD y al pasar a ser empleado (o continuar en mi empleo) del Empleador en cualquier momento a partir del 1.° de marzo de 2014 o posteriormente, acepto y acuerdo cumplir estos requisitos de resolución de conflictos. Entiendo que el Empleador también acepta y acuerda cumplir estos requisitos de resolución de conflictos. Todos los reclamos cubiertos presentados por mi cónyuge, mis hijos, mis padres, mis beneficiarios, mis Representantes, mis ejecutores, mis administradores, mis tutores, mis herederos o mis cesionarios también están sujetos a la política de resolución de conflictos del Empleador, y cualquier decisión de un árbitro será definitiva y vinculante para dichas personas y el Empleador. **Entiendo que el árbitro, y no el juez ni el jurado, tiene la autoridad exclusiva para resolver cualquier conflicto sobre exigibilidad de este proceso de resolución de conflictos.**

X _____ Firma del Asociado	_____ Fecha
_____ Nombre del Asociado en Letra de Imprenta	_____ Número de Identificación del Asociado
_____ Firma del Padre, de la Madre o del Tutor Legal (si el Asociado es menor de 18 años)	_____ Fecha
_____ Nombre del Padre, de la Madre o del Tutor Legal en Letra de Imprenta	_____ Lugar de Trabajo o Departamento del Asociado

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Este folleto y este formulario contienen información importante sobre sus derechos. Al dorso de este formulario encontrará la información en español. Si tiene dificultad en entender cualquier parte de este folleto, comuníquese con el Departamento de Manejo de Riesgo, Risk Management Department, al (281) 584-1390.

Sign and Turn In

RECEIPT, SAFETY PLEDGE AND DISPUTE RESOLUTION ACKNOWLEDGEMENT

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Firmar y entregar

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